STATE OF INDIANA

ANTHEM TRADITIONAL PLAN II

JANUARY 2004

This booklet is for educational purposes only and it is not intended to serve as legal interpretation of benefits. Reasonable effort is made to have this booklet represent the intent of the plan language. However, the plan language stands alone and is not considered as supplemented or amended in any way by the explanations of examples included in this booklet.

Anthem Blue Cross and Blue Shield does not insure or underwrite the liability of the State of Indiana under this Plan. The State of Indiana retains ultimate responsibility for claims made under the Plan except for the contractual responsibilities assumed by Anthem under the terms of the Contract for Health Benefit Administrative Services with the State of Indiana.

Administered by:
Anthem Insurance Companies, Inc.
d/b/a
Anthem Blue Cross and Blue Shield

Customer Service Number:
Business Hours are 8:00 a.m. to 5:00 p.m. Central Time

Medical Questions - 1-877-814-9709

Precertification Program Unit:
1-877-814-4803

Mental Health or Substance Abuse Program
1-800-223-7723

Employee Assistance Program
1-800-223-7723

Pharmacy Program
1-800-662-0210

Claims Mailing Address:
Anthem Insurance Companies, Inc.
PO Box 37010
Louisville, KY 40233-7010

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PART I: OVERVIEW OF IMPORTANT INFORMATION

The Medical Plan provided by the State of Indiana, as explained in this booklet, is available to you and your eligible dependents defined in Part VII of this booklet. The benefits are available for covered expenses incurred after the "Effective Date of Your Coverage" explained on Page 30.

Covered Services: Services or supplies for which benefits will be paid when rendered by providers acting within the scope of their license. To be considered a covered service, charges for that service must be incurred while the enrollee's coverage under the plan is in force.

All covered services and supplies must be medically necessary. Medically Necessary means that services or supplies are required for treatment of illness, injury, diseased condition or impairment and the place of treatment is appropriate for the level of care.

Covered Charges: Charges for covered services to the extent that in the judgment of the Corporation, as authorized by the State of Indiana, such charges are not excessive. The Corporation will base its judgment on one or a combination of the following: a) a negotiated rate based on services provided; b) a fixed rate per day; or c) the Reasonable Charge for similar providers who perform like covered services.

Your Deductible: The Plan Deductible is: $0.00 per Enrollee; $0.00 per family. See Page 6 for further information.

Your Out-of-Pocket Expense: The Out-of-Pocket Limit includes all percentage Co-payments you incur in a Benefit Period. However, Prescription Drug Co-payments do not apply toward the Out-of-Pocket Limit. Once the Member and/or family Out-of- Pocket Limit is satisfied, no additional percentage Co-payments will be required for the Member and/or family for the remainder of the Benefit Period except for Prescription Drug Co-payments. See page 6 for further information.

Network and out-of-network percentage Co-payments and Out-of-Pocket Limits **do accumulate toward each other.** Prescription Drugs are subject to separate Co-payments.

Plan Maximum: Your Plan contains a lifetime maximum payment of $1,000,000.00. This means the lifetime maximum amount of benefit payments available to you and each of your eligible dependents, for as long as you are covered under this Plan, is $1,000,000.00.

Blue Access Network: Your coverage includes a Provider Network. In order to receive full Plan benefits, you must choose a provider who is a part of this Network. **If you DO NOT choose a Network Provider, you will be required to pay an additional 40% of the Covered Charges, unless otherwise stated herein.** See Page 6 for further information about the Blue Access Network.

PRECERTIFICATION: When you are admitted to the hospital, for any reason other than mental illness or substance abuse, you are required to call PRECERTIFICATION and pre-certify your hospital admission. The medical consultants in PRECERTIFICATION will coordinate your treatment program with the hospital and your doctor, assuring you receive the best possible care, while using the most cost-effective treatments. **If you do not call PRECERTIFICATION, your Inpatient benefits will be reduced by 50%.** The phone number to call is on your identification card. See Page 3 for additional information about PRECERTIFICATION.

Managed Mental Health Network: When you receive **Inpatient** care for Mental Illness or Substance Abuse, you are required to call to pre-authorize your care. **If you choose an In-Network Provider**, you will receive full Plan benefits. **If you choose a Non-Network Provider**, you will receive reduced benefits. See Page 19 for additional information about the Managed Mental Health Network.

Employee Assistance Program: The Employee Assistance Program provides consultation and referral services for human concerns for employees and their household members. See Page 19 for additional information about the Employee Assistance Program.

Pharmacy Network: When you purchase covered drugs from an **IN-NETWORK PHARMACY**, you and your Eligible Dependents each will be required to pay a $10 co-payment for Formulary Generic drugs; a $20 co-payment for Formulary Brand name drugs; or a 40% co-payment (with a minimum payment of $40 and a maximum payment of $100) for non-Formulary Generic or Brand name drugs. When you purchase covered drugs from the **MAIL SERVICE PROGRAM**, you and your Eligible Dependents each will be required to pay a $20 co-payment for Formulary Generic drugs; a $40 co-payment for Formulary Brand name drugs; or a 40% co-payment (with a minimum payment of $80 and a maximum payment of $150) for non-Formulary Generic or Brand name drugs. You will not need to file a claim if you receive services from an in-network pharmacy. When you purchase covered drugs from an **OUT-OF-NETWORK** pharmacy, your co-payment will be 40% of the charge for Brand name or Generic drugs, whether Formulary or non-Formulary. You must pay the full amount to the pharmacy and file a claim with Anthem Insurance Companies, Inc. Your agency designee will have a supply of claim forms. There are no out-of-network benefits for the Mail Service Program. See Page 16 for additional information about the Pharmacy Network. **Do not file the deductible or co-payment amount with Anthem Insurance Companies, Inc.**

REFER TO THE LAST PAGE OF THIS BOOKLET FOR PHONE NUMBERS YOU MAY CALL FOR MORE INFORMATION ON YOUR BENEFITS, THE BLUE ACCESS NETWORK, PRECERTIFICATION, THE MANAGED MENTAL HEALTH NETWORK AND THE PHARMACY NETWORK.

PART II: PRECERTIFICATION

(See Part IV, Managed Mental Health, for information on how to pre-certify mental illness and substance abuse services.)

Health Care Management is included in the Enrollee's health care benefits to encourage the Enrollee to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Enrollees by assuring the use of appropriate procedures, setting (place of service), and resources using Precertification, Concurrent Review, and Case Management.

For each Health Care Management feature, the purpose of the feature, what is required, and effects on benefits are explained.

PRECERTIFICATION

NOTICE: Precertification does NOT guarantee coverage for or the payment of the service or procedure reviewed.

Precertification is a procedure which requires that an approval be obtained from the Plan before incurring expenses for certain Covered Services. When care is evaluated, both Medical Necessity and appropriate length of stay will be determined. For certain services the Enrollee will be required to use the Provider designated by the Contractor's Health Care Management staff, on behalf of the State. Medical Necessity includes a review of both the service and the setting. When approved, a copy of the approval will be provided to the Enrollee, the Physician, and the Hospital or facility. The care will be covered according to the Enrollee's benefits for the number of days approved unless the Contractor's Concurrent Review, on behalf of the State, determines that the number of days should be revised. Most Providers know which services require Precertification and will obtain any required Precertification. The Enrollee's Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. If the Enrollee uses a Non-Network Provider, the Enrollee will be responsible for any services which are not Medically Necessary. If a request is denied, the Provider may request a reconsideration to be completed within 3 days of the request. An expedited reconsideration may be requested when the Enrollee's health requires an earlier decision.

The Enrollee is requested to obtain Precertification for certain services obtained from a Non-Network Provider; or, if the Enrollee is traveling or lives outside of the Service Area and has used the BlueCard program to obtain a Network or Participating Provider through the local Blue Cross and Blue Shield Plan.

When the Enrollee is requested to obtain Precertification, the Enrollee should verify that the Non-Network Provider obtains the requested Precertification or the Enrollee should obtain the requested Precertification. If the Enrollee does not obtain any requested Precertification, the Enrollee is responsible for all charges for services the Contractor determines are not Medical Necessary. If the Enrollee fails to obtain Precertification, a retrospective review will be done to determine if the Enrollee's care was Medically Necessary.

If the Enrollee has any questions regarding Health Care Management or to determine which services require Precertification, the Enrollee should call the telephone number on the back of the Identification Card.

For Emergency admissions, Precertification is not required. However, the Enrollee is requested to notify the Contractor and/or the Plan or the Enrollee's Physician of the admission within 48 hours or as soon as possible within a reasonable period or services after 48 hours could be denied.

CONCURRENT REVIEW

Concurrent Review is a process in which nurses monitor the Enrollee's progress during an Inpatient admission. As a result of Concurrent Review, additional days of Inpatient care may be approved which exceed the number originally authorized by the Contractor's Health Care Management staff, on behalf of the State. With prior notice from the Contractor, on behalf of the State, the number of days originally authorized through Precertification may be reduced when it is determined that continued Inpatient care is no longer Medically Necessary.

For concurrent review, the determination should be made within one business day after all information is provided and notice of the decision is required within one business day after the determination.

CASE MANAGEMENT (INCLUDES DISCHARGE PLANNING)

Case Management is a feature designed to assure that the Enrollee's care is provided in the most appropriate and cost effective care setting. This feature allows the Plan to customize the Enrollee's benefits by approving otherwise non-covered services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Contractor's Health Care Management staff, on behalf of the State. In managing the Enrollee's care, the Plan has the right to authorize substitution of Outpatient Services or services in the Enrollee's home to the extent that benefits are still available for Inpatient Services.

INTERACTIVE REAL-TIME INFORMATION SHARING (IRIS)

IRIS is a health management technique that can collect clinical health information and identify potential errors and gaps in care, helping to avert potential problems for at-risk Members before they experience dangerous, costly events. IRIS uses technology to examine current technical and historical patient information and determine risks to the patient. The at-risk Member and the Member's Physician will be contacted by one of the Contractor's medical directors to discuss a coordinated plan of care. Follow-up communications may be necessary depending upon the severity of the case.

DISEASE MANAGEMENT PROGRAMS

Disease management programs offer extra information to Members who:

- are at a high risk for pregnancy complications.
- have suffered a heart attack or had surgery related to coronary artery disease.
- have diabetes.

Disease management is also provided for other chronic, complex and costly diseases including, but not limited to, asthma, chronic obstructive pulmonary disease, and congestive heart failure.

Members will receive educational information from the Contractor if their claims indicate they are receiving treatment for a chronic disease. Interventions are geared for Members who present an opportunity to improved clinical, financial, safety and humanistic outcomes.

PART III: BENEFITS

PLAN DEDUCTIBLE

During each calendar year, you must first satisfy the deductible amount shown below, before **any** benefits can be paid under the medical plan.

The Plan Deductible is:

$0.00 per Enrollee; $0.00 per family.

CO-PAYMENT

You will be responsible for network co-payments stated as dollar amounts or percentages. **The plan will reduce payment to 60% and your co-payment will increase to 40% if you receive services from a non-network provider, unless otherwise stated herein.**

OUT-OF-POCKET LIMIT

The Out-of-Pocket Limit per calendar year of covered charges is:

$2,000.00 per Enrollee; $4,000.00 per family.

After you have paid the out-of-pocket limit, the plan will begin paying 100% of the Reasonable Charge for your covered charges for the remainder of that calendar year, unless otherwise stated herein.

PLAN MAXIMUM

The Plan Lifetime Maximum is $1,000,000.00 per Enrollee.

BLUE ACCESS NETWORK

There will be an out-of-network penalty an Enrollee receives services from a provider who is **NOT** a Network Provider. This penalty does accrue toward the maximum out-of-pocket limit. Out-of-network penalties will not apply to emergency accident or emergency illness care or to an employee whose principle residence is more than 30 miles from a network provider or to an out-of-state provider.

HOSPITAL INPATIENT

Exception: See Managed Mental Health Care benefits for treatment of Mental Illness and Substance Abuse.

Hospital - A facility that is a short-term, acute care general hospital and which:

a) is a duly licensed facility,

b) for compensation from its patients, is primarily engaged in providing inpatient diagnosis, treatment, and care of injured and sick persons by, or under the supervision of, physicians,

c) has organized departments of medicine and major surgery, and

d) provides 24-hour nursing service by, or under the supervision of, Registered Nurses.

Network Inpatient facility services are subject to a $500 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Network Inpatient professional services are covered in full. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

OUTPATIENT SERVICES

Outpatient Services Other Than Surgery

Network Outpatient surgical services other than surgery are covered in full. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Outpatient Surgical Services

Network Outpatient facility services are subject to a $250 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Outpatient Professional Services

Network Outpatient professional services are covered in full. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

PHYSICIAN SERVICES

The following physician services are covered:

1. Surgery

NOTE: If more than one (1) surgical procedure is performed during one (1) session, this Plan will pay the benefits stated above for the most costly procedure. The other procedure(s) will be paid at 50% of Covered Charges. Incidental surgical procedures will not be covered by the Plan.

No additional fee will be paid to a network provider, for a secondary operation or procedure following the primary operation, such as reopening the incision for exploration, removal of hematoma, control of bleeding, resuturing, and similar services connected with the original service.

2. Services of an assistant surgeon when your physician needs assistance, not to exceed 20% of the total surgical allowance.

3. General anesthesia when administered during surgery by a physician other than the operating surgeon (nurse anesthetists are covered providers).

4. One consultation per hospital confinement for each diagnosis.

   Exception: See Managed Mental Health Care benefits for treatment of Mental Illness and Substance Abuse.

5. One inpatient medical visit per diagnosis, per physician, each day you are hospitalized. During surgical admissions, the diagnosis must be different from the surgical diagnosis.

Exception: See Managed Mental Health Care benefits for treatment of Mental Illness and Substance Abuse.

6. Intensive medical care.

7. Voluntary second or third surgical opinions.

Network Physician Office services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Reconstructive Surgery

Covered Services for reconstructive surgery following mastectomies are:

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Benefits paid for Mastectomy Reconstruction are 80% of the Reasonable Charge.

If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Mastectomy Note

An Enrollee who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual Deductible, Copayment provisions otherwise applicable under the Plan.

MATERNITY

Your plan will pay the hospital and physician charges the same as for any other condition for you and your covered dependents.

Maternity benefits are available on both single and family enrollments for services provided after the effective date of your coverage.

INITIAL NEWBORN TESTING

Benefits include initial newborn examinations for detecting the following disorders at the earliest feasible time: phenylketonuria; hypothyroidism, hemoglobinopathies, including sickle cell anemia; galactosemia; Maple Syrup urine disease; homocystinuria; and inborn errors of metabolism that result in mental retardation and that the state department designates; physiologic hearing screening examinations for newborns to detect hearing impairments; congenital adrenal hyperplasia; biotinidase deficiency; disorders detected by tandem mass spectroscopy or other

technologies with the same or greater capabilities as tandem mass spectrometry - a newborn is exempt from this examination only if a parent objects, in writing, because of religious beliefs.

Your plan will pay 80% of the Reasonable Charge for Initial Newborn Testing.

If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

NEWBORN INITIAL and SUBSEQUENT EXAMS

Network Physician Office services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

HOME AND OFFICE CALLS

Network Physician Office services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

WELLNESS BENEFIT

Well Baby Immunizations

Network services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Limit: Well baby immunizations must be for children less than two (2) years of age.

Routine Physical

Network services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Flu Shots

Network services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Routine Pap Smears

Network and out-of-network services are covered in full.

ROUTINE PROSTATE ANTIGEN TESTS (PSA)

Network and out-of-network services are covered in full.

BLOOD

Your plan will pay 80% of covered charges for blood.

If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

MEDICAL AIDS

Prosthetic Devices

Covered services are the initial purchases, fitting, repair, and replacement of fitted devices, which replace body parts or perform bodily functions.

Network services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Durable Medical Equipment

Covered services are the rental, initial purchase, repair and replacement of equipment appropriate for home use and manufactured mainly to treat the injured or ill.

Exception: Routine maintenance is not a covered service and Covered Charges for deluxe items are limited to the cost of standard items.

Network services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Orthotic Appliances

Covered services are the initial purchase, fitting, repair and replacement of braces, splints, and other appliances used to support or restrain a weak or deformed part of the body.

Exceptions: Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace, and standard elastic stockings, garter belts, and other supplies not specifically made and fitted are not Covered Services.

Network services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

OUTPATIENT DIAGNOSTIC SERVICES

The following procedures are covered when ordered by a provider individual because of specific symptoms:

a. radiology, ultrasound, and nuclear medicine;
b. laboratory and pathology;
c. EKG,EEG, and other electronic diagnostic medical procedures;
d. Psychological testing;
e. Neuropsychological testing

EXCEPTIONS: Unless otherwise provided, your benefits do not include the following services:

1. audiometric testing (when performed to determine the necessity of a hearing aid);
2. eye refractions;
3. examinations for fitting of eye glasses, contact lenses or hearing aids, dental examinations;
4. premarital examinations; or
5. research studies, screening examinations; physical examinations or checkups.

Your plan will pay 100% of the Reasonable Charge for Outpatient Diagnostic Services. **Network Physician Office services are Covered In Full. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.**

ROUTINE MAMMOGRAMS

Benefits includes one routine mammogram per calendar year. Additional mammography services and ultrasounds are covered as determined Medically Necessary by your physician.

Network and out-of-network services are covered in full.

PREADMISSION TESTING

Covered services are necessary tests and studies performed in an outpatient setting before an inpatient hospital admission.

Services are not covered if:

1. performed to establish a diagnosis.
2. repeated after admission to the hospital.
3. performed more than seventy-two (72) hours before the date of admission.
4. if the admission is canceled or postponed.

Your plan will pay 80% of the Reasonable Charge for diagnostic services performed in an outpatient setting.

If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

DENTAL CARE

In and outpatient hospital and physician charges for dental care are covered if you have an unrelated medical condition which makes it unsafe to perform the dental procedure anywhere else. Benefits will be paid the same as any other condition.

Accidental Dental

Covered services--treatment of dental caused by an accidental injury occurring after your effective date of coverage.

Your Plan will pay 80% of the Reasonable Charge subject to the Plan Deductible.

OUTPATIENT THERAPY SERVICES

Therapy services means the following services and supplies ordered by a Provider Individual used for the treatment of an illness or injury to promote the recovery of the Enrollee or Eligible Dependent.

1. Radiation Therapy - Treatment of disease by x-ray, radium, or radioactive isotopes.

2. Chemotherapy - The treatment of disease by chemical or biological antineoplastic agents.

3. Dialysis treatments - The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body; includes hemodialysis or peritoneal dialysis.

4. Physical Therapy - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

5. Respiratory/Inhalation Therapy - The introduction of dry or moist gases into the lungs for treatment purposes.

6. Occupational Therapy - Treatment designed to improve muscle strength, joint motion, coordination and endurance of a physically disabled person, when given by a Physical Therapist or an Occupational Therapist.

7. Speech Therapy - Treatment for the correction of a speech impairment resulting from an accident, a stroke, or surgery.

Network services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

EMERGENCY CARE

Emergency Illness - A medical condition that is not accident-related and characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

a) Permanently placing your health in jeopardy, or

b) Other serious medical consequences, or

c) Serious impairment of bodily function, or

d) Serious and permanent dysfunction of any bodily organ or part.

Network and out-of-network emergency care services are subject to a $75 co-payment.

Emergency Accident - A sudden external event resulting in bodily injury. It does not include physical conditions resulting from sickness or disease.

Network and out-of-network emergency care services are subject to a $75 co-payment.

URGENT CARE SERVICES

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment. Urgent Care services can be obtained from a Network or Non-Network Provider. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified for emergency room care.

Network and out-of-network urgent care services are subject to a $35 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME

Covered services for TMJ Syndrome are Inpatient Hospital charges, office visits, Diagnostic Services, Orthotic appliances, equilibrations, crowns, orthodontia, and Surgery.

Your Plan will pay 80% of the Reasonable Charge for services related to TMJ Syndrome.

Limit: $2,500.00 Lifetime Maximum per Enrollee

If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

HOME HEALTH CARE

Covered services are non-custodial medical and nursing care to home confined patients who are referred to a Home Health Care Agency by a Physician.

Custodial Care--is a non-covered service. Custodial care is defined as:

1. Care with the primary purpose of meeting personal rather than medical needs, including services such as, assistance in walking, getting in and out of bed, dressing, feeding, use of toilet, preparation of special diets, and supervision medication, which can be self-administered.

2. Care which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or medical condition.

3. Care which persons with no special medical skills or training can provide.

The Plan will determine, based on medical evidence, whether care is custodial. Services determined to be custodial will not be covered, regardless of who prescribes or provides the treatment.

Network Home Health Care services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

HOSPICE CARE

Covered services include physician services, nursing care, medical appliances and supplies, drugs, for outpatient care for pain relief and symptom management, inpatient short term care including respite care, home health aids, homemaker services, physical therapy, occupational therapy, and speech pathology services, and counseling including dietary counseling.

Your plan will pay 100% of the Reasonable Charge for Hospice Care.

AMBULANCE

Covered services are medically necessary ambulance services, provided by a hospital or a government certified ambulance service, in a vehicle designed and equipped to transport the sick and injured. Both air and ground ambulance services are included in this benefit.

Network or Non-Network ambulance services are subject to a $50 co-payment.

PHARMACY NETWORK

Covered services are insulin, insulin syringes, and all drugs and medicines requiring a prescription under federal law. Covered Services also includes medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical foods means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

When you purchase covered drugs from an **IN-NETWORK PHARMACY**, you and your Eligible Dependents each will be required to pay a $10 co-payment for Formulary Generic drugs; a $20 co-payment for Formulary Brand name drugs; or a 40% co-payment (with a minimum payment of $40 and a maximum payment of $100) for non-Formulary Generic or Brand name drugs.

When you purchase covered drugs from an **OUT-OF-NETWORK** pharmacy, your co-payment will be 40% of the charge for Brand name or Generic drugs, whether Formulary or non-Formulary. You must pay the full amount to the pharmacy and file a claim with Anthem Insurance Companies, Inc. Your agency designee will have a supply of claim forms. There are no out-of-network benefits for the Mail Service Program.

NOTE: The Network Penalty will be waived if there is no network pharmacy within 12 miles of your home.

Limits: A maximum of 34 days of medication or 100 units of medication (whichever is greater) may be purchased at one time.

EXCLUSIONS:

- Over the counter drugs
- Over the counter vitamins
- Prescription vitamins (covered if treating a medical condition)
- Birth Control Devices
- Retin-A (covered if treating a medical condition)
- Diet Pills (Anorexiants)
- Fluoride Supplements
- Experimental/ Investigative drugs

Mail Service Program

When you purchase covered drugs from the **MAIL SERVICE PROGRAM**, you and your Eligible Dependents each will be required to pay a $20 co-payment for Formulary Generic drugs; a $40 co-payment for Formulary Brand name drugs; or a 40% co-payment (with a minimum payment of $80 and a maximum payment of $150) for non-Formulary Generic or Brand name drugs. You will not need to file a claim if you receive services from an in-network pharmacy.

EXCLUSIONS:

- Over the counter drugs
- Over the counter vitamins
- Prescription vitamins (covered if treating a medical condition)
- Birth Control Devices
- Retin-A (covered if treating a medical condition)
- Diet Pills (Anorexiants)
- Fluoride Supplements
- Experimental/ Investigative drugs

Limits: Maximum of 90 days of medication may be purchased at one time.

CLAIMS FOR THE PHARMACY CO-PAYMENT OR DEDUCTIBLE ARE YOUR RESPONSIBILITY AND SHOULD NOT BE FILED WITH ANTHEM INSURANCE COMPANIES, INC.

See Part VI for "What the Medical Plan Does Not Cover."

DIABETES SELF MANAGEMENT TRAINING

Covered Services include 1 visit after initial diagnosis
1 visit for refresher training
1 visit if significant change in condition

Network services are subject to a $20 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

INJECTIBLE DRUGS AND HOME IV THERAPY

Benefits are payable for injectible drugs and home IV therapy services.

Your plan will pay 80% of the Reasonable Charge for Injectible Drugs and Home IV Therapy.

If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

SCREENING COLORECTAL CANCER EXAMINATION

Screening colorectal cancer examination and related laboratory test and office visits are covered for eligible enrollees and eligible dependents. The maximum number of screening colorectal cancer examination and related laboratory tests and office visits payable under this Plan is one (1) per enrollee or dependent per calendar year.

Network and out-of-network services are covered in full.

MORBID OBESITY

Covered services include surgical treatment by a Provider of morbid obesity that has persisted for at least (5) years; and for which non-surgical treatment that is supervised by a Physician has been unsuccessful for at least (18) consecutive months.

Limit: one procedure per lifetime.

Your plan will pay 80% of the Reasonable Charge for Morbid Obesity.

If you receive services from an out of the network provider, benefits will decrease to 60% of covered charges.

PART IV: MANAGED MENTAL HEALTH

MANAGED MENTAL HEALTH (INCLUDING SUBSTANCE ABUSE)

You and your covered family members are eligible for a full range of managed mental health and substance abuse (MHSA) treatment through the Member Assistance Program (MAP).

To use the MAP services, you must call 1-800-223-7723 to get authorization. When you call, the staff will provide a referral to appropriate care and help you or your covered dependents choose a provider.

Inpatient Benefits

Network Inpatient facility services are subject to a $500 co-payment. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Network Inpatient professional services are covered in full. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Remember, you need to pre-authorize all Inpatient Mental Health and Substance Abuse services.

Intensive Outpatient Benefits

Intensive Outpatient services are more highly structured and intensive (e.g. 3-4 hours a day, 3-5 times a week) than outpatient therapy or counseling with a private provider.

Network Outpatient professional services are covered in full. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Outpatient Benefits

Network Outpatient professional services are covered in full. If you receive services from an out-of-network provider, benefits will decrease to 60% of Covered Charges.

Remember, to receive the highest level of benefits, you must stay within the Provider Network.

For outpatient visits with In-network providers, you do not need to submit claims. For outpatient visits with out-of-network providers, send claims to:

Magellan Behavioral Health
P.O. Box 1129
Maryland Heights MO 63043

EMPLOYEE ASSISTANCE PROGRAM

Your Employee Assistance Program (EASY) provides you and your household members with confidential consultation and referral services at no cost to you. You can receive assistance over the phone for a wide range of issues including:

- Family problems, including problems with children;
- Child care and elder care;

- Legal concerns;
- Financial issues, including budget management and debt consolidation;
- Housing concerns.

The Employee Assistance counselor will also coordinate the personal aid you receive. You may call the counselor anytime, day or night, for crisis help or any other concern. The private Employee Assistance Help Line will be answered 24 hours a day, seven days a week by an employee assistance counselor.

The assistance you receive is strictly confidential. Information is not shared with your employer or family members.

To reach a counselor, call toll free 1-800-223-7723.

See Part VI for "What The Medical Plan Does Not Cover."

PART V: HUMAN ORGAN TRANSPLANTS

Human Organ and Tissue Transplant Services
For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Benefit Period	Total of 365 continuous days beginning 1 day immediately prior to a Covered Transplant Procedure or first myeloblation therapy (high dose chemotherapy and/or irradiation).

Transplant Maximum

Lifetime Maximum per Member for all Transplant Services, under this Plan or any successive Human Organ and Tissue Transplant Benefit between the Member and the Company	$1,000,000 Network and Non-Network Transplant Provider services combined

NOTE: Transportation/Lodging/Meals, Procurement, and Hospital Confinement are included in and accrue toward this lifetime maximum for all Transplant Services.

Transplants at a Non-Network Facility do not count towards the Deductible or the Out-of-Pocket maximum.

The total dollar amount the Plan will pay is $1,000,000 per Member for all Transplant Services including the Covered Transplant Procedure, under Benefit Booklet or any preceding or succeeding Human Organ and Tissue Transplant Benefit Booklet or Human Organ and Tissue Transplant offered by the Employer.

Non-Network Transplant Facility

Transplant Services provided through a Non-Network Transplant Facility, with respect to the type of Covered Transplant Procedure performed:

> If the Covered Transplant Procedure is performed in a Non-Network Transplant Facility, the Plan will pay the lesser of 60% of billed charges, or 60% of the amount shown below for the actual Covered Transplant Procedure. This amount will accrue to the $1,000,000 Lifetime Maximum. These amounts may be eligible for Covered Transplant Procedure expenses during the 30 day period beginning one day prior to the Covered Transplant Procedure for solid organ transplants, and one day prior to myeloblative therapy for bone marrow/stem cell transplants. After the 30th day, remaining transplant services other than the Covered Transplant Procedure expenses, may be eligible at 60% of billed charges for the remainder of the 365 day Benefit Period, not to exceed the $1,000,000 Lifetime Maximum.

The Maximums below include organ acquisition for a solid organ transplant; and mobilization, harvesting and storage of marrow/cells, regardless of when it occurs, for a bone marrow/stem cell transplant.

	NETWORK TRANSPLANT FACILITY	**NON-NETWORK TRANSPLANT FACILITY**
Transplant Services With respect to the type of Covered Transplant Procedure performed:	Member pays a $2,000 Co-payment	Plan pays the lesser of 60% of billed charges, or 60% of the amount shown in the schedule below.

Adult Procedures	Charge Maximum
(Includes organ /tissue acquisition)	
Adult Heart	$68,800
Adult Lung	$97,000
Adult Heart/Lung	$133,600
Adult Procedures	**Charge Maximum**
Adult Liver	$97,600
Adult Pancreas	$75,200
Kidney/Pancreas	$75,200
Adult Autologous Bone Marrow including High Dose Chemotherapy	$56,000
Adult **Related** allogeneic Bone Marrow including High Dose Chemotherapy	$80,000
Adult **Unrelated** allogeneic Bone Marrow including High Dose Chemotherapy	$88,000

Pediatric Procedures	Charge Maximum
(Includes Organ/Tissue Acquisition)	
Pediatric Autologous Bone Marrow including High Dose Chemotherapy	$66,400
Pediatric **Related** Allogeneic Bone Marrow including High Dose Chemotherapy	$93,600
Pediatric **Unrelated** Allogeneic Bone Marrow including High Dose Chemotherapy	$115,200
Pediatric Heart	$104,000
Pediatric Liver	$106,400

	NETWORK TRANSPLANT FACILITY	NON-NETWORK TRANSPLANT FACILITY
Transportation Lodging and Meals	Included in the Transplant Services Co-payment	60% Co-payment

Reasonable and necessary travel expenses related to a transplant at a Non-Network Transplant Facility are covered at the Non-Network Transplant Facility Co-payment level.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Covered Transplant Procedure

Any of the following Medically Necessary Human Organ and Tissue Transplants:

Adult Procedures

- Bone marrow or stem cell including:

  - Autologous Bone Marrow including High Dose Chemotherapy

  - Related allogeneic Bone Marrow including High Dose Chemotherapy

  - Unrelated allogeneic Bone Marrow including High Dose Chemotherapy

- Heart;
- Heart/Lung;
- Lung;
- Liver;
- Pancreas and Kidney when preformed simultaneously or Pancreas transplant after a Kidney transplant (Kidney transplant alone may be covered under medical and is not part of this transplant benefit)

Pediatric Procedures

- Bone marrow or stem cell including:

  - Autologous Bone Marrow including High Dose Chemotherapy

  - Related allogeneic Bone Marrow including High Dose Chemotherapy

  - Unrelated allogeneic Bone Marrow including High Dose Chemotherapy

- Heart;
- Liver;

As additional diagnoses cease to be Experimental/Investigative, the Employer may amend the above Covered Transplant Procedure list to include such procedures.

When the Administrator, on behalf of the Employer, considers a Human Organ or Tissue Transplant to be Experimental/Investigative the transplant and all Covered Services performed in relation to the transplant are excluded under this benefit. If a covered Human Organ or Tissue Transplant is done in conjunction with an Experimental/Investigative transplant, the Administrator, on behalf of the Employer, will determine the portion of the charges which relate to the covered Human Organ or Tissue Transplant and allow only those charges.

You are strongly encouraged to call the Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. The Administrator, on behalf of the Employer, will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or Benefit Booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Benefit Period

Transplant coverage starts one day prior to the organ transplant surgery or one day prior to myeloblation therapy (high dose chemotherapy and/or irradiation). Any services performed more than one day prior to the transplant are eligible for coverage under the medical benefit with the exception of services in conjunction with BMT/Stem Cell harvesting. Transplant coverage ends the earlier of the following:

- 364 days from the date of the transplant surgery or first myeloblation therapy;
- The day before a re-transplant, if within one year. (Upon re-transplant a new transplant benefit period starts.)

Transplant Related Expenses

Transplant Related Expenses mean Medically Necessary items that are required as a result of a Covered Transplant Procedure and would not be incurred if the person were not having a Covered Transplant Procedure. Services related to the diagnosis causing the need for a Covered Transplant Procedure which would have been performed whether or not the patient received a Covered Transplant Procedure are not considered a Transplant Related Expense. Transplant Related Expenses during a transplant benefit period include only the following:

- Acquisition costs, also referred to as procurement (live or cadaver). Acquisition costs include Medically Necessary services in connection with the preparation, harvesting and storage of bone marrow, stem cell or solid organ for a Covered Transplant. For a living donor, acquisition costs also include the Medically Necessary Inpatient services for the recovery of the donor post surgery and any complications that arise as a direct result of the actual acquisition procedure for a period of six weeks from the date of the acquisition or as otherwise determined within the limits determined by the Plan. Cord blood is payable if the transplant is approved. Harvesting and storage of cord blood, bone marrow or stem cells for a possible future transplant is not eligible under this transplant benefit.

- Transportation, meals and lodging. The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator, on behalf of the Employer, when you obtain prior approval and are required to travel more than 75 miles from your residence to reach a Network Transplant Facility. The Plan's assistance with travel expenses includes transportation to and from the Network Provider facility, lodging and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Administrator, on behalf of the Employer, when claims are filed. Contact the Administrator, on behalf of the Employer, for detailed information.

- Hospital charges and professional fees for the Covered Transplant Procedure.

- Inpatient Services, Outpatient Services, or Home Care Services for treatment of complications of bone marrow or stem cell transplant, or for complications and/or rejection of the transplanted organ.

- Physician fees for medical care following Hospital discharge, which are identified as post transplant.

The Employer may, at its sole discretion, cover services and supplies not specifically covered by the Benefit Booklet.

PART VI: WHAT THE MEDICAL PLAN DOES NOT COVER

EXCLUSIONS

This Plan provides no benefits for:

Unless specifically stated in this Plan's Benefits' Article, care and supplies related to:

- Services and supplies provided in connection with a human organ or tissue transplant, except that benefits will be provided for the following:

  Cornea or kidney transplants; and

  Services and supplies, including immunosuppressive drugs, required after the 18 months following a heart, liver, or non-investigational bone marrow transplant, related to the diagnosis and/or treatment of a rejected transplant organ or tissue.

- Services and supplies for artificial heart implants.
- Services and supplies for artificial insemination.
- Services and supplies for in vitro fertilization.
- Services and supplies for gamete intra fallopian transfer (GIFT).
- Services and supplies for a sex change.
- Services and supplies for immunizations except as specifically stated.
- Services and supplies for radial keratotomy.
- Services and supplies for sterilization reversal.
- Services of a provider who is the enrollee’s spouse, child, brother, sister, parent, or in-law.
- Eyeglasses, contact lenses, or examinations to prescribe or fit such items (eye refractions), except that the cost of the first pair of either eyeglasses, contact lenses, or intraocular lenses required following cataract surgery is not excluded.
- Hearing aids or examinations to prescribe or fit them.
- Services, supplies, or charges which the Plan determines are not Medically Necessary.
- Custodial Care.
- Services and supplies for Dental, except as specifically stated.
- Private Duty Nursing services, except when provided through the Home Health Care benefit.
- Charges which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Contractor.
- Care of flat feet; (2) supportive devices of the foot, such as arch supports or pelvic/spinal stabilizers (even if specifically made for and fitted to a particular individual); (3) care of corns, bunions, or callouses; (4) care of toenails; and (5) care of fallen arches, weak feet, or chronic foot strain. However, items (3) and (4) are covered when medically necessary because of diabetes or circulatory problems.
- Charges for services or supplies for occupational accidents and diseases, which are or could, have been paid for or available under the requirements of Worker's Compensation and Occupational Disease Law.
- Wellness including physicals and premarital examinations, and any other routine or periodic exams, except as specifically stated.
- Services or supplies for research studies, or screening examinations, except as specifically stated.

- Services or supplies for or related to developmental delays except for Pervasive Developmental Disorders (including Asperger's syndrome and autism) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, learning disabilities, hyperkinetic syndromes, or mental retardation (except for Prescription Drugs).
- Treatment of any illness or injury resulting from any act of war which an Enrollee sustains while covered.
- Services or supplies to the extent the Enrollee has no legal obligation to pay for them.
- Expenses incurred before an Enrollee's coverage becomes effective, or after it ends.
- Services or supplies provided by a sanitarium, or rest cures.
- Services or supplies furnished by any person or institution acting beyond the scope of her/his/its license.
- Plan benefits to the extent that the services are a Medicare Part A or Part B liability.
- Services or supplies received from a dental or medical department maintained by or on behalf of a Plan Sponsor, a mutual benefit association, labor union, trust or similar person or group.
- Services provided by any governmental agency to the extent provided without cost to the enrollee except as this exclusion may conflict with federal or state law.
- Travel, whether or not recommended by Physician.
- Services or supplies if the Plan does not state that benefits are provided for them.
- Telephone consultations, charges for failure to keep a scheduled visit or charges for completion of a claim form.
- Recreation or diversional therapy.
- Cost of materials used in any Occupational Therapy.
- Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a Physician prescribes such items.
- Hospitalization for environmental change or Provider Individual charges connected with prescribing an environmental change.
- Services or supplies for treatment of obesity and/or weight control except as specifically stated in this Benefit Booklet.
- Services and supplies related to the treatment of abuse of nicotine from tobacco or other sources, except for nicotine substitutes, which require a prescription under federal law.
- Stand by charges of a Physician.
- Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
- Drugs in quantities, which exceed the limits, established by the Plan.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, and/or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, is excluded from coverage for the first 6 months after the date the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may, in its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Prescription drugs, except as provided through the Anthem Pharmacy Program.
- The prescription drug co-payment portion of the Anthem Pharmacy Program.
- Any medications dispensed in a physician's office.
- Services and supplies for Norplant or other surgically implanted contraceptives.
- Late fees or finance charges.
- Treatment of temporomandibular joint (TMJ) syndrome, except as specifically stated as covered.
- Services and supplies for fertility counseling and treatment. However, benefits are provided for diagnostic services performed to determine the cause of infertility.
- Services and supplies for marriage counseling.
- Services and supplies received from an individual or entity that is not a Provider.
- Services and supplies for a condition resulting from a riot, civil disobedience, nuclear explosion, or nuclear accident.

- Mileage costs or travel expenses, except as authorized by the Corporation.
- Services which are solely performed to preserve the present level or function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Services and supplies primarily for educational, vocational, or training purposes.
- Expenses incurred at a health spa or similar facility.
- Self-help training and other forms of non-medical self care, except as otherwise provided herein.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
- Services and supplies for Skilled Nursing Facilities.

PART VII: GENERAL INFORMATION

ELIGIBILITY

All active full-time employees, elected and appointed officials are eligible for Medical coverage and employees and their household members are eligible for the Employee Assistance Program.

Present dependents become eligible on the date the employee, elected or appointed official becomes eligible. Newly acquired dependents become eligible on the date they acquire dependent status.

No plan shall become effective unless the employee, elected or appointed official has completed an enrollment card authorizing deductions for premium contributions for the employee and/or the employee's eligible dependents.

EFFECTIVE DATE OF YOUR COVERAGE

After you enroll or change from single to family coverage, the effective date is four days after the date premium deductions have been taken from your pay warrant. For agencies billed monthly, the effective date will be the first of the month following the contribution.

Coverage for a newborn child is effective from the moment of birth. Covered services include the treatment of any injury or illness such as congenital deformity, hereditary complication, premature birth, and routine nursery care. Routine well-baby care, and medical examinations or tests of any kind, not related to treatment of illness or injury, are not covered.

DEPENDENTS

You may include your spouse as a dependent. You may also include your unmarried dependent children until the end of the year of their 19th birthday (or the end of the year of their 23rd birthday, if the dependent is a full-time student at an educational institution). See your agency designee for a student certification form. Dependent children include unmarried natural children, stepchildren, foster children, legally adopted children or children who reside in your home for whom your or your spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an accredited educational institution). Such child shall remain a dependent until marriage or the end of the calendar year in which he/she attains age 19/23. Any child enrolled prior to his or her 19th birthday who is totally dependent on you because of a mental or physical disability may be continued on your enrollment for as long as the disability lasts, if your application to continue coverage is received within 120 days of the date the child becomes ineligible.

In addition, for purposes of the Employee Assistance Program, the definition of "dependent" shall also include any permanent resident of the household.

Dependents may be added as your personal status changes. If you marry or acquire an eligible dependent child, notify the payroll/personnel section of your agency immediately. Submit all necessary forms within 30 days of the event to your agency. Delay in making application could lead to the rejection of a claim for the new dependent.

These changes must be made within 30 days of the event. Otherwise, the change must be made during the next open enrollment.

NEWBORN INFANT COVERAGE

The benefits payable for eligible Dependent children shall be paid for a sick or injured newborn infant of an Eligible Person for the first 31 days of his or her life. The coverage for newly adopted children will be the same as for other Eligible Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth

abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:

    a) The date of placement for the purpose of adoption; or
    b) The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;

2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or

3. Continues unless required action as described below is not taken.

To be covered beyond the first 31 days, the newborn or newly adopted child must be added to the Eligible Person's Plan enrollment within the first 31 days after birth or adoption. If the enrollee must change to coverage with a higher fee to add the child, the Enrollee will be liable for the higher fee for the entire period of the child's coverage, including the first 31 days.

FEDERAL LAWS RELATED TO YOUR COVERAGE

In the past few years, Congress has passed several laws that have affected our group health plans. These laws are designed to reduce Medicare expenditures by requiring that active employees and/or their dependents who are either age 65 or over, or disabled to elect either:

a) our group health plan, or
b) Medicare as their primary coverage.

The preference is option (a) since option (b) would require the discontinuance of the group medical plan. In addition, Medicare no longer requires enrollment in the Part B Supplemental Medical Insurance Benefit for which there is a charge so long as you remain covered under our group medical plan.

INDIVIDUAL TERMINATION

Your plan will terminate on the earliest of the following dates:

1. On the date the group plan is terminated.

2. On the date you withdraw your enrollment and payroll deduction authorization for premium contribution on behalf of yourself and/or your dependents.

3. On the last day of the period for which premiums have been paid, if the State of Indiana fails to pay the required premiums for you, except when resulting from clerical mistake or inadvertent error.

4. On the last day of the period for which premiums have been paid in which you leave or are dismissed from employment.

5. On the date your dependent(s) cease(s) to be an eligible dependent.

6. Upon the date of your death, coverage for your dependents shall terminate at the end of the period for which premiums have been paid.

7. Coverage for any eligible dependent child shall cease on the last day of the calendar year in which he/she ceases to qualify as a dependent.

CONTINUATION COVERAGE ELIGIBILITY

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides employees and their dependents the opportunity for continuation coverage under our group health plan after their coverage would otherwise have terminated.

1. You may choose continuation coverage for yourself and your eligible dependents for up to 18 months if:

   a) Your employment is terminated, including retirement, or
   b) Your work hours are reduced, resulting in a loss of coverage.

2. You or your eligible dependents may choose to extend the continuation coverage period for up to 29 months if:

   a) Social Security determines that you or your dependent is disabled, and you notify Anthem Insurance Companies, Inc., within 60 days of the 18-month period.

   b) The disabled person would be eligible for the extended period of coverage not to exceed a total of 29 months from the date of termination, retirement, or work hour reduction, which resulted in loss of benefits.

3. Your spouse and eligible dependents may choose continuation of coverage for up to 36 months following:

   a) Your death,
   b) Divorce (you must provide notification),
   c) Your eligibility for Medicare while maintaining the continuation coverage,
   d) Ceasing to be an eligible dependent child.

CANCELLATION OF CONTINUOUS COVERAGE

Your continuous coverage may be canceled if:

1. Premiums are not paid,
2. You, your spouse, or your dependents become covered under another group health plan or Medicare, unless the group health plan contains an exclusion or limitation with respect to any pre-existing condition. Coordination of Benefits may apply.
3. Your spouse remarries and becomes covered under another group health plan.

4. You cease to be disabled. You must notify Anthem Insurance Companies, Inc., within 30 days of Social Security's determination that the disability no longer exists. Coverage will terminate 30 days after the Social Security determination date.

MEDICAL EXAM

We have the right to have a physician examine the patient when a claim is made under the plan as often as is reasonably required during the pendency of the claim. We will notify you in advance of the time and place if such an examination is required.

FILING CLAIMS

If an Indiana physician or hospital treats you, most claims will be filed for you if you show the hospital or physician your identification card. The same is true if you are a hospital bed patient at most out-of-state hospitals. Under other conditions, however, you may be required to file your own medical claims. To do so:

Ask the hospital employee or physician to fill out the claim form normally filed with Anthem Insurance Companies, Inc., or obtain an itemized bill showing each service, the charge for each, and the diagnosis. The bill should also show who the patient is and describe his/her relationship to the person listed on your identification card.

Copy all numbers from your identification card on the bill or claim form and mail it to:

Anthem Insurance Company Inc.
P.O. Box 37010
Louisville, KY 40233-7010

Try to have bills in a foreign language translated before you submit them, and mail both the bill and the translation.

KEEP A COPY OF ALL BILLS FOR YOUR RECORDS

FILING CLAIMS: MEDICARE SECONDARY

After Anthem Insurance Companies, Inc. has processed your claims, you will receive a "Notice of Your Benefits". For any eligible balance remaining for "Part B", if you are enrolled, attach that summary to a completed Medicare claim form and submit it to:

Anthem Insurance Companies, Inc.
P.O. Box 7073
Indianapolis, IN 46207

Medicare "Part A" participating providers will file both Medicare and Anthem Insurance Companies, Inc., claims on your behalf. Medicare claims must be filed with the Medicare carrier in the state where services were performed.

CLAIM FILING TIME LIMIT

For benefits to be payable under the Plan, Anthem Insurance Companies, Inc. must receive a claim by December 31 of the year following the year the service was received. However, Anthem Insurance Companies, Inc., will not

reduce or deny benefits for failure to meet this time limit if the claim was filed as soon as it was reasonably possible for the enrollee to do so.

INQUIRY PROCEDURE

To assist you in answering any additional questions you may have, a toll free telephone number is available directly to the State of Indiana Operations Unit.

Medical Questions- 1-877-814-9709

COORDINATION OF BENEFITS

If you or one of your dependents is covered by another group health plan, and both plans cover the same service, the total benefit paid by both plans will be adjusted so that payment does not exceed the allowable charge for the covered service.

One of the plans will be designated "primary", and the other will be designated "secondary". The primary plan will provide its normal benefits. The secondary plan will pay the difference between what the primary plan has paid and the allowable charge. Neither plan will provide more benefits under coordination of benefits than it would if there were no other coverage.

How to file under both plans:

If the employee is the patient:

1. File under your employer's health plan first.

2. File under the other plan second.

If the spouse is the patient:

1. File under the spouse's plan first.

2. File under your employer's plan second.

If a dependent is the patient:

1. When two or more plans cover the same patient and the parents are legally married:

    a) File under the plan of the parent whose birthday falls earlier in the year first; other parent's plan second.
    b) File under the plan that covered the parent longer, if both parents have the same birthday; other parent's plan second.
    c) File under the plan without the "birthday rule" first; other plan second.

2. When two or more plans cover the same patient and the parents are separated or divorced, claims should be filed in this order (unless a court decree states otherwise):

a) Under the plan of the parent with custody, first.
b) Under the plan of the spouse of the parent with custody, second.
c) Under the plan of the parent without custody, last.

If an active employee also has coverage as a retiree under another plan:

1. File under the plan, which covers the enrollee as an active employee first.

2. File under the plan, which covers the enrollee as a retiree second.

   Both active and retiree plans must have this rule; otherwise payment will be made by the plan that has been in effect longer.

   When the order of payment cannot be determined in accordance with these general guidelines, file first under the plan that has covered the patient for the longer period of time, then under the plan that has covered the patient the shorter period of time.

   In order for us to process your claims, you should send the first plan's Explanation of Benefits form to us when you submit your claim.

   If you or one of your dependents is covered by two group plans with Anthem Insurance Companies, Inc., and both cover the same service, benefits will be coordinated in a similar manner.

Limits: When this plan is determined to be the secondary plan, it will not pay secondary benefits on any prescription drug charges, if such charges were incurred in connection with a prescription drug pharmacy program. An example of a prescription drug pharmacy program is the Pharmacy Network program contained in this benefit plan.

Anthem may periodically request other insurance information from you or your covered dependents to keep our records updated.

SUBROGATION

These provisions apply when Plan benefits are paid as a result of injuries or illness sustained by the Enrollee and for which the Enrollee has a right to a Recovery or has received a Recovery.

The Contractor, on behalf of the State, has the right to recover payments made on behalf of the Enrollee from any party responsible for compensating the Enrollee for the Enrollee's injuries. The following apply:

The Contractor, on behalf of the State, has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether the Enrollee is fully compensated, and regardless of whether the payments the Enrollee receives makes the Enrollee whole for his or her losses and injuries.

The Enrollee and the Enrollee's legal representative must do whatever is necessary to enable the Contractor, on behalf of the State, to exercise their rights and do nothing to prejudice them.

The Contractor, on behalf of the State, have the right to take whatever legal action they see fit against any party or entity to recover the benefits paid under this Plan.

To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Contractor's subrogation claim and any claim still held by the Enrollee, the Contractor's

subrogation claim shall be first satisfied before any part of a Recovery is applied to the Enrollee's claim, attorney fees, other expenses or costs.

The Contractor, on behalf of the State, is not responsible for any attorney fees, other expenses or costs without its prior written consent. The Contractor, on behalf of the State, further agrees that the "common fund" doctrine does not apply to any funds recovered by any attorney hired by the Enrollee regardless of whether funds recovered are used to repay benefits paid by the Contractor, on behalf of the State.

REIMBURSEMENT

If the Enrollee obtains a Recovery and the Contractor, on behalf of the State, has not been repaid for the benefits the Contractor, on behalf of the State, paid on the Enrollee's behalf, the Contractor, on behalf of the State, shall have a right to be repaid from the Recovery in the amount of the benefits paid on the Enrollee's behalf and the following apply:

The Enrollee must reimburse the Contractor, on behalf of the State, to the extent of benefits the Contractor, on behalf of the State, paid on the Enrollee's behalf from any Recovery.

Notwithstanding any allocation made in a settlement agreement or court order, the Contractor, on behalf of the State, shall have a right of Recovery, in first priority, against any Recovery.

The Enrollee and the Enrollee's legal representative must hold in trust for the Contractor, on behalf of the State, the proceeds of the gross Recovery (i.e., the total amount of the Enrollee's Recovery before attorney fees, other expenses or costs) to be paid to the Contractor, on behalf of the State, immediately upon the Enrollee's receipt of the Recovery. The Enrollee must reimburse the Contractor, on behalf of the State, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney the Enrollee hires regardless of whether funds recovered are used to repay benefits paid by the Contractor, on behalf of the State.

If the Enrollee fails to repay the Contractor, on behalf of the State, the Contractor, on behalf of the State, shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Contractor, on behalf of the State, has paid or the amount of the Enrollee's Recovery whichever is less, from any future benefit under the Plan if:

The amount the Contractor, on behalf of the State, paid on the Enrollee's behalf is not repaid or otherwise recovered by the Contractor, on behalf of the State; or

the Enrollee fails to cooperate.

In the event that the Enrollee fails to disclose to the Contractor and/or the State the amount of the Enrollee's settlement, the Contractor, on behalf of the State, shall be entitled to deduct the amount of the lien from any future benefit under the Plan.

The Contractor, on behalf of the State, shall also be entitled to recover any of the unsatisfied portion of the amount they have paid or the amount of the Enrollee's settlement, whichever is less, directly from the providers to whom the Contractor, on behalf of the State, has made payments. In such a circumstance, it may then be the Enrollee's obligation to pay the provider the full billed amount, and the Contractor, on behalf of the State, would not have any obligation to pay the provider.

The Contractor, on behalf of the State, is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make the Enrollee whole.

THE ENROLLEE'S DUTIES

The Enrollee must notify the Contractor, on behalf of the State, promptly of how, when and where an accident or incident resulting in personal injury or illness to the Enrollee occurred and all information regarding the parties involved.

The Enrollee must cooperate with the Contractor, on behalf of the State, in the investigation, settlement and protection of the rights of the Contractor, on behalf of the State.

The Enrollee must not do anything to prejudice the rights of the Contractor, on behalf of the State.

The Enrollee must send the Contractor, on behalf of the State, copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to the Enrollee.

The Enrollee must promptly notify the Contractor, on behalf of the State, if the Enrollee retains an attorney or if a lawsuit is filed on the Enrollee's behalf.

WORKER'S COMPENSATION

The benefits that would be payable under your plan will be reduced by charges payable under the Worker's Compensation and Occupational Disease Law.

RIGHT OF RECOVERY

We may recover any incorrect payment. If the incorrect payment is made directly to you, we may deduct it from future payments made directly to you.

BLUECARD PROGRAM

When the Enrollee receives health care services outside the geographic area served by Anthem Blue Cross and Blue Shield and those services are administered through the BlueCard Program, the amount the Enrollee pays for Covered Charges will usually be calculated on the **lower** of:

- The provider's actual billed charges for the Enrollee's covered services, or
- The negotiated price passed on to Anthem by the Blue Cross and/or Blue Shield Plan within the area where services are received.

Often, this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that includes expected settlements and other non-claims transactions with a provider or with a discount from billed charges that reflects **average** expected savings. The estimated or average price may be prospectively adjusted to correct for over- or underestimation of past prices.

In addition, laws in certain states require Blue Cross and/or Blue Shield Plans to use a basis for calculating the Enrollee's payment for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim. When the Enrollee receives covered services for health care in those states, the Enrollee's payment will be calculated using their statutory methods.

LEGAL ACTION

No legal action to obtain the Plan's benefits may be taken prior to 60 days after the Contractor received the claim, or later than three (3) years after the date the claim is required to be furnished to the Contractor.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

Neither the Contractor nor the Plan Sponsor is responsible for the quality of care you or your dependents receive from any person. This Plan does not give anyone any claim, right, or cause of action against the Contractor or the Plan Sponsor, based on what a provider of health care or supplies does or does not do.

DEFINITIONS

"Ambulatory Surgical Facility" means a facility that is so licensed by the state in which it operates. If that state does not issue such licenses, it means a facility with an organized staffs of Physicians which:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis, and
b. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility, and
c. does not provide Inpatient accommodation, and
d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Provider Individual, and
e. has appropriate government planning approval, if required by its state law.

"Benefit Maximum" means the total dollar amount of benefits for which the Plan is liable under this Plan's Benefits Article.

"Brand Name Drug" means the initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own Brand name, or under the drug's chemical name (Generic).

"Certified Registered Nurse Anesthetist" means any individual licensed as a registered nurse by the state in which he or she practices, holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a re certification process administered by the Council on Re certification of Nurse Anesthetists.

"Clinical Laboratory" means a laboratory that performs clinical procedures and is not affiliated or associated with a Hospital, Physician, or other Provider.

"Community Mental Health Center" means a facility which, (1) offers a program of services approved by the Indiana Department of Mental Health, or by the state in which it operates, (2) is organized for the purpose of providing multiple services for persons with Mental Illness, including Substance Abuse, and (3) is operated by one or more of the entities named in I.C. 16-16-1-1 or similar entities of the state where it is located.

"Confinement" means a period beginning on the day an enrollee enters a Provider Facility as a patient and ending on the day the enrollee leaves that facility or, if the enrollee was transferred from one Provider Facility to another, the day on which the enrollee leaves the last facility. In order for a new Confinement to begin, a specified number of renewal days must elapse before the enrollee is readmitted to a Provider Facility.

"Contract" means all of the following: 1) this document, all Contract Schedules, Attachments, Addendum's and Riders; 2) all applications to establish and change enrollments that have been accepted by the Contractor; 3) all Identification Cards; and 4) Contract for Health Benefit Administrative Services between the State of Indiana and Anthem Insurance Companies, Inc.

"Contract Maximum" means: the total dollar amount, as stated in this Contract's Benefits Article, for which the Plan is liable under this Contract.

"Contract Year" means: January 1 through December 31.

"Contractor" means Anthem Insurance Companies, Inc.

"Co-payment" means the percentage of Covered Charges for which the Enrollee is responsible under the terms of the Plan. Co-payment takes effect after any Deductible is met and before any Stop Loss Limit is reached.

"Covered Charges" means charges for Covered Services to the extent that, in the judgment of the Contractor, as authorized by the Plan Sponsor, such charges are not excessive. The Contractor will base its judgment on one or a combination of the following: a) a negotiated rate based on services provided; b) a fixed rate per day; c) the Reasonable Charge for similar Providers who perform like Covered Services.

"Covered Services" means services or supplies specified in this Plan for which benefits will be paid when provided by a Provider acting within the scope of his/her/its license. In order to be considered a Covered Service, charges for that service must be incurred while the Enrollee's coverage under this Plan is in force.

"Custodial Care" means care whose primary purpose is to meet personal rather than medical needs, which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or medical condition, and which can be provided by persons with no special medical skills or training. Such care includes, but is not limited to, helping a patient walk, get in or out of bed, and take normally self-administered medicine. The Corporation, on behalf of the Plan Sponsor, will determine, based on reasonable medical evidence, whether care is custodial.

"Day Psychiatric Facility" means a facility licensed or certified by the state in which it operates as a provider of rehabilitation and therapeutic services for the treatment of Mental Illness, including Substance Abuse only during the day.

"Dentist" means a duly licensed dentist or physician who is performing services within the scope of his or her license.

"Dependent" means Spouse of an employee, any unmarried dependent children, step-children, foster children, legally adopted children or children who reside in the Enrollee's home for whom the Enrollee or spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an accredited educational institution). Such child shall remain a "dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the employee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "dependent" will continue until the employee discontinues his coverage or the disability no longer exists.

"Dependent Limiting Age" The Limiting Age is the end of the Calendar Year of the child's 19th birthday, or if the child is a full-time student, the end of the calendar year of the child's 23rd birthday.

"Diagnostic Services" means the following procedures ordered by a Provider Individual, because of specific symptoms, in order to determine a definite condition or disease:

a. radiology, ultrasound, and nuclear medicine;
b. laboratory and pathology;
c. EKG, EEG, and other electronic diagnostic medical procedures;
d. psychological testing;
e. neuropsychological testing.

Diagnostic Services are covered to the extent specified under this Plan's Benefits Article.

"Effective Date" means coverage for employee, other than those on a direct bill basis, becomes effective on the fourth (4th) day following the first payroll deduction. For agencies billed monthly, the effective date will be the first of the month following the first contribution. Coverage for dependents takes effect when the employee becomes covered.
Newborns are covered from and after the moment of birth for injuries or sickness, congenital deformities, including expenses arising from medical treatment for birth defects known as cleft lip and cleft palate, hereditary complications, premature birth and routine nursery care. Continued coverage requires adding dependents to existing coverage by the 30th day from birth.

If these complications occur on a single membership, the baby is covered for thirty-one (31) days from the date of birth. Continued coverage requires election of family coverage by the 30th day from birth.

"Eligible Person" means a person who meets the guidelines for eligibility under the Plan.

"Enrollee" means anyone provided coverage by the express terms of this Plan, whether enrolled as an Eligible Person or a Dependent.

"Experimental/Investigative" means any drug, device, diagnostic, product, equipment, procedure, treatment, or supply (service) for which the Contractor, on behalf of the Plan Sponsor, determines that one or more of the criteria listed below apply to the service when it is rendered for the evaluation or treatment of a disease, injury, illness or condition. The criteria must apply to the service at the time the Member, receives or will receive the service, and must apply to the medical use for which benefits are sought. The service:

- cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- is the subject of a current drug or device application on file with the FDA;
- is provided as part of a Phase I or Phase II clinical trial, is provided as the experimental or research arm of a Phase III clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service;
- is provided pursuant to a written protocol or other document that lists an evaluation of the service's safely, toxicity, or efficacy among its objectives;
- is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- is provided pursuant to informed consent documents that describe the service as Experimental/Investigative, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative if the Contractor, on behalf of the Plan Sponsor, determines that the service meets any of the four criteria below:

- the scientific evidence does not permit conclusions concerning the effect of the service on health outcomes;

- the service does not improve net health outcome by producing beneficial effects that outweigh any harmful effects;
- the service has not been shown to be as beneficial as any of the established alternative services with evidence demonstrating that the service improves net health outcome as much as, or more than, established alternatives; or
- the service has not been shown to improve net health outcomes under the usual conditions of medical practice outside clinical investigatory settings.

Documents relied upon by the Contractor to determine whether services are Experimental/Investigative based on the criteria in the above subsections may, at the Contractor's discretion, on behalf of the Plan Sponsor, include one or more items from the following list which is not all inclusive:

- the Member's medical records;
- the written protocol(s) or other document(s) pursuant to which the service has been or will be provided;
- the published, authoritative, peer-review medical or scientific literature regarding the service as it applies to the Member's condition;
- any consent document(s) the Member or Member's representative have executed or will be asked to execute to receive the service;
- the relevant documents of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided;
- any records, regulations, applications or other documents or actions issued by, filed with, or received by the FDA, the Office of Technology Assessment, or other federal or state agencies with similar functions, that the Contractor, on behalf of the Plan Sponsor, has in its possession at the time of the review; or
- opinions and evaluations by national medical associations or committees, consensus panels, or other technology evaluation bodies, such as the Blue Cross and Blue Shield Association's Technology Evaluation Center.

Services provided solely or primarily to support the administration of an Experimental/Investigative service, or those provided to treat anticipated or unanticipated results of an Experimental/Investigative service, will also be excluded from coverage. Services that are part of the same plan of evaluation or treatment as an Experimental/Investigative service, but which, in the opinion of the Contractor, on behalf of the Plan Sponsor, would, in the absence of the Experimental/Investigative service be otherwise Medically Necessary, may be considered eligible for coverage, subject to all benefit requirements, limitations and exclusions.

The Plan Sponsor has the sole authority and discretion to determine all questions pertaining to whether a service is Experimental/Investigative under this Plan.

"Formulary" means the list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

"Freestanding Dialysis Facility" means a facility which is primarily engaged in providing dialysis treatment, maintenance, or training to patient on an Outpatient or home care basis.

"Generic Drugs**"** means drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicate those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

"Home Antibiotic IV Therapy" means the administration of antibiotics intravenously, by trained personnel, in the patient's home.

"Home Health Care Agency" means an agency meeting Medicare requirements and licensed by the state(s) in which it operates to provide Home Health Care.

"Hospital" means a facility, which is a short-term, acute care general hospital and which:

a. is a duly licensed facility, and
b. for compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of Physicians, and
c. has organized departments of medicine and major surgery, and
d. provides 24-hour nursing service by or under the supervision of RNs.

"Identification Card" means a card issued by the Contractor, on behalf of the Plan Sponsor, that bears the Enrollee's name, identifies his or her benefit program by number, and may contain further information about his or her coverage.

"Inpatient" means an enrollee who is treated as registered bed patient in a Provider Facility and for whom a room and board charges is made.

"Intermediate Care Facility" means a licensed, residential public or private Substance Abuse Rehabilitation Facility that is not a Hospital and is operated primarily to provide continuous, structured 24 hour a day or partial, less than 24 hour a day, treatment and care consisting of chemotherapy, counseling, detoxification, and/or ancillary services, identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs.

"Licensed Practical Nurse" (LPN) means a person who has graduated from a formal practical nursing education program and is license as such by appropriate state authority.

"Mail Service" means a prescription drug program which offers a convenient means of obtaining maintenance medications by mail if the Insured takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with the Administrator, on behalf of the Plan Sponsor, and sent directly to the Member's home.

"Medically Necessary or Medical Necessity" means services or supplies received for the treatment of an illness or injury or other health condition that is determined to be:

- appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards;
- not chiefly Custodial in nature;
- not Experimental/Investigative or unproven;

- not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment, and as to institutional care, cannot be provided in any other setting, such as a Physician's office or the outpatient department of a Hospital, without adversely affecting the patient's condition; and
- not provided only as a convenience to you, your Physician or another Provider or person.

The fact that any particular Physician may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary.

The fact that any particular Provider Individual may prescribe, order, recommend, or approve a service, supply of level of care does not, of itself, make such treatment Medically Necessary or make the charge a Covered Charge under this Plan.

"Medicare" means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental Health Treatment Center" means a treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician. The facility shall be:

1. Licensed by the state in which it operates;
2. Funded or eligible for funding under federal or state law; or
3. Affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Mental Illness including Substance Abuse" means (1) Mental Illness, which is a clinically significant behavioral or psychological disorder, marked by a pronounced deviation from a normal healthy state and associated with a present painful symptom or impairment in one or more important areas of functioning. This disease must not be merely an expectable response to a particular stimulus. (2) Substance Abuse, which is a condition, brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost. The Contractor, on behalf of the Plan Sponsor, will make final benefit determination based upon reasonable medical evidence.

"Network" means the provider network established by Anthem Insurance Companies Inc.

"Night Psychiatric Facility" means a place where patients with Mental Illness, including Substance Abuse, who are capable or remaining in the community during the day, can receive treatment at night. A Night Psychiatric Facility may be a ward or wing of a Hospital or Psychiatric Hospital or it may be an independent facility that has been licensed or certified by the state in which it operates as a provider of psychiatric night care and assumes responsibility for coordinating care of all patients.

"Occupational Therapist" means a person who is licensed as such by the state in which he or she practices or, if that states does not issue such licenses, it means a person certified as such by an appropriate professional body.

"Out-of-Pocket Limit" means the amount of Covered Charges, including the Deductible, which an Enrollee must pay before his or her benefits under this Plan increase to 100% of Covered Charges for the remainder of the Deductible period. Covered charges for Mental Illness and Substance Abuse do not accrue to the Out-of-Pocket Limit and benefits for them do not increase to 100% of Covered Charges when the Out-of-Pocket Limit is reached.

"Out-of-Pocket Limit Exception" Covered Charges for the following do not accrue to the Out-of-Pocket Limit and benefits for them do not increase to 100% of Covered Charges when the Out-of-Pocket Limit is reached:

Outpatient Substance Abuse.

"Outpatient" means an Enrollee who is a patient, other than a bed patient, at a Provider Facility.

"Outpatient Psychiatric Facility" means a facility licensed or certified by the state in which it operates as a provider of rehabilitation and therapeutic services for the treatment of Mental Illness, including Substance Abuse, on an Outpatient basis.

"Partial Hospitalization" means a psychiatric service offered in a Hospital or in a psychiatric day care treatment center or in a Community Mental Health Center providing medically directed intensive or intermediate short-term psychiatric treatment for a period of less than 24 hours but more than 4 hours a day for any individual patient.

"Pharmacy" means any facility so licensed by the state in which it operates.

"Physical Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

"Physician" means a doctor of medicine, a doctor of osteopathy, a psychologist, a chiropractor or any other practitioner of the healing arts who is licensed by the appropriate agency, is practicing within the scope of that license and:

1. Is not an Enrollee receiving treatment from himself or herself; and
2. Is not a person who usually resides in the same household with the patient; or is related by blood, marriage, or legal adoption to the patient or the employee's spouse.

"Plan" means all of the following: 1) this document, all Contract Schedules, Attachments, Addendums and Riders; 2) all applications to establish and change Enrollments that have been accepted by the Contractor; 3) all Identification Cards; and 4) Contract for Health Benefit Administrative Services between the State of Indiana and Anthem Insurance Companies, Inc.

"Plan Deductible" means a specified amount of Covered Services, usually expressed in dollars, that must be incurred by an Enrollee before the Plan will assume any liability for all or part of the remaining Covered Services. The Deductible will not apply to expenses for routine nursery care and supplies incurred by a newborn, if the mother has maternity coverage. If two or more persons covered by the same coverage are injured in the same accident, only a single Deductible will be applied to all Covered Charges that are accident related.

"Plan Description" means all of the following: 1) this document, and all Plan Schedules and Riders; 2) all applications to establish and change Plan Enrollments that have been accepted by the Contractor on behalf of the Plan Sponsor; 3) all Identification Cards; 4) Summary of Plan description.

"Plan Enrollment" means an Eligible Person's or Dependent's right to this Plan's benefits subject to its Exclusions, limitations, and conditions.

"Plan Maximum" means the total dollar amount of benefits for which the Plan is liable under this Plan's Benefits Article.

"Plan Sponsor" means the legal entity contracting with the Contractor for the administration of health care benefits. Plan Sponsor has full and final authority and responsibility for the Plan and its operation.

"Plan Year" means the 12-month period beginning each January 1.

"Psychiatric Hospital" means a facility licensed by the state in which it operates to provide diagnostic and therapeutic services for treatment of Mental Illness, including Substance abuse, on an Inpatient basis. If the state does not issue such licenses, it means a facility which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness and Substance abuse, if such services are provided by or under the supervision of an organized staff of Physicians and if continuous nursing services are provided by RNs.

"Psychologist" means a person certified by the Indiana State Board of Examiners in Psychology or, outside the State of Indiana, one who is licensed or certified as such by the state in which he or she practices. Where there is no state licensure or certification, the Psychologist must be certified by an appropriate professional body

"Reasonable Charge" means the maximum amount that is determined to be reasonable for Covered Services you receive, up to but not to exceed charges actually billed. This determination considers:

- amounts charged by other Providers for the same or similar service;
- any unusual medical circumstances requiring additional time, skill or experience;
- other factors determined are relevant, including but not limited to, a resource based relative value scale; and
- The amount accepted by a Network Provider as payment in full under the participation agreement for this Plan.

For a Network Provider, the Reasonable Charge is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the maximum Reasonable Charge.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Contractor for another product, the Reasonable Charge is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

For a Provider who has a participation agreement with the Contractor, the Reasonable Charge is equal to the amount that constitutes payment in full under any participation agreement with the Contractor. If a Provider accepts as full payment an amount less than the negotiated rate under a participation agreement, the lesser amount will be the maximum Reasonable Charge.

"Recovery" means money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

"Registered Nurse" (RN) means a person who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed as such by appropriate state authority.

"Rehabilitation Facility" means a facility licensed by the state in which it operates to provide rehabilitative care on an Inpatient or Outpatient basis. If the state does not issue such licenses, it means a facility which is primarily engaged in providing medical, social, educational, and vocational services to enable patients, when the services are Medically Necessary, to achieve the highest possible level of functional ability. Services must be provided by or under the supervision of an organized staff of Physicians and continuous nursing services must be provided under the supervision of registered nurses.

"Residential Short Term Detoxification Facility" means a facility licensed or certified by the state in which it operates to provide 24-hour supervision in a structured therapeutic environment for the treatment and re socialization of Substance Abuse patients.

"Respiratory Inhalation Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

“Semi-private room” means the charge made by a Hospital for a room containing two or more beds.

"Speech Pathologist or Speech Therapist" means a person so licensed by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as a Speech Pathologist or Speech Therapist by an appropriate professional body.

"Skilled Care" means (1) the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury; and (2) must be performed by or under the supervision of licensed health care personnel.

"Spouse" means the person recognized as the Eligible Person's husband or wife under the laws of the state where the contract is held.

"Substance Abuse Facility" means a facility licensed or certified by the state in which it operates as a provider of detoxification and/or rehabilitation treatment for Substance Abuse patients.

FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENTS, OR BILLINGS

CUSTOMER SERVICE NUMBER

Business Hours are 8:00 A.M. to 5:00 P.M. Central Time.

Medical Questions -1-877-814-9709

PRECERTIFICATION

1-877-814-4803

MENTAL HEALTH OR SUBSTANCE ABUSE PROGRAM

1-800-223-7723

EMPLOYEE ASSISTANCE PROGRAM

1-800-223-7723

PHARMACY NETWORK

1-800-662-0210

PLEASE HAVE YOUR IDENTIFICATION NUMBER READY WHEN YOU CALL

This booklet is for educational purposes only and it is not intended to serve as legal interpretation of benefits. Reasonable effort is made to have this booklet represent the intent of the plan language. However, the plan language stands alone and is not considered as supplemented or amended in any way by the explanations of examples included in this booklet.

Anthem Blue Cross and Blue Shield does not insure or underwrite the liability of the State of Indiana under this Plan. The State of Indiana retains ultimate responsibility for claims made under the Plan and all expenses incident to the Plan except for the contractual responsibilities assumed by Anthem under the terms of the Contract for Health Benefit Administrative Services with the State of Indiana.